

Real Improvements Sustainable Progress Better Lives For Nebraskans

A DHHS BUSINESS PLAN

"Helping People Live Better Lives"

Department of Health & Human Services



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MESSAGE FROM THE CEO



COURTNEY N. PHILLIPS, CEO

"Helping people live better lives."
Those five words guide the work of our DHHS team every day along with the attributes outlined in our values and core competencies. All Nebraskans can expect a commitment to excellence, integrity, fiscal responsibility, positivity, professionalism, transparency and accountability.

These behaviors and attitudes are the foundation of our can-do culture that is transforming DHHS. We've already seen significant advances in providing Nebraskans with the responsive, high-quality and efficient services they deserve.

I'm pleased to present the Department's first business plan. The business plan will serve as a road map through June 2017. It outlines 25 agency priorities and goals. The plan follows the lead and support of Governor Pete Ricketts to improve the performance of state government through strategic actions and measurable outcomes.

As we move forward, we'll share our successes and look for opportunities as we face our challenges.

We're making great strides and I'm proud of the DHHS team. We're here because we believe in what we do and we're dedicated to helping Nebraskans live better lives.

A handwritten signature in black ink, appearing to read 'Courtney N. Phillips', followed by a long horizontal line extending to the right.

Executive Summary

History shows Nebraska has been caring for its citizens even prior to achieving statehood in 1867. Over time, state government has changed but our commitment to the people we serve remains steadfast.

The Nebraska Department of Health and Human Services touches the lives of Nebraskans every day, and when people interact with the Department, the goal is to make the experience a positive one.

Our team has worked diligently to improve our responsiveness and service to our state's most vulnerable citizens.

Governor Pete Ricketts assembled a dynamic team of DHHS directors who share their experience and insight to move the Department forward and continue to develop high-quality, efficient, and customer-friendly services to help Nebraskans live better lives.

Governor Ricketts has identified five priorities for his administration and this business plan strategically aligns DHHS with them. The Governor's priorities are:

- ▶ A more efficient and effective state government
- ▶ A more customer-focused state government
- ▶ Grow Nebraska
- ▶ Improve public safety
- ▶ Reduce regulation and regulatory complexity



This business plan will guide the current and future work of the Department through June 2017. Its focus is to outline DHHS priorities, define goals, and chart progress as we continue our efforts to improve services and effectively manage resources.

The plan will also ensure a new level of transparency and accountability for the benefit of taxpayers.

The Department has identified 25 priorities that will result in real improvements, sustain current progress, and help Nebraskans live better lives. They are grouped under five categories that span the work of the Department:

- ▶ Integrating Services and Partnerships
- ▶ Promoting Independence through Community-Based Services
- ▶ Focusing on Prevention to Change Lives
- ▶ Leveraging Technology to Increase Effectiveness
- ▶ Increasing Operating Efficiencies and Improvements

Integrating Services and Partnerships

Integrating services across our Department into a more effective, efficient, comprehensive, and coordinated system helps state government, through the Department, deliver better outcomes to the people we serve with greater value for taxpayers. Working across divisions, disciplines, and programs, together with our partners, simplifies processes for consumers, increases quality of care and is more efficient and effective.

There are four DHHS priorities in this category:

- ▶ Heritage Health (Medicaid Managed Care)
- ▶ Behavioral Health System of Care for Children, Youth and Families
- ▶ Family-Focused Case Management in Economic Assistance
- ▶ Cross-Division Solutions Team

Promoting Independence through Community-Based Services

DHHS continues its work to ensure people are being served in supportive and safe environments, including within their own communities. In recent years, state-implemented reforms have transformed its service delivery system for people and greatly expanded and enhanced community capacity, and minimized reliance on institutional services.

Community-based services that are built on the needs of our varied customers provide needed support to help them maintain independence and flourish in their respective communities. Engaging with

stakeholders through a focus on customer service will guide our work.

There are four priorities in this category:

- ▶ Developmental Disabilities Home and Community-Based Waivers, and Community-Based Transition Plan
- ▶ Developmental Disabilities Registry of Unmet Needs
- ▶ Long-Term Services and Supports (LTSS) Redesign Project
- ▶ Increasing Access to Evidence-Based Community Treatment Services for At-Risk Youth

Focusing on Prevention to Change Lives

Prevention is key to a healthy life and longevity. Prevention can take many forms, whether it is preventing disease or providing support to families and improving public safety to prevent child abuse or neglect. DHHS is investing in healthy behaviors and growing Nebraska by working with Nebraskans to achieve lifelong success and potentially save lives.

There are three priorities in this category:

- ▶ Prescription Drug Overdose Prevention and Prescription Drug Monitoring Program
- ▶ Expansion of Alternative Response
- ▶ Reduction in Out-of-Home Placement of State Wards by Safely Expediting Reunifications

Leveraging Technology to Increase Effectiveness

Technology is a valuable tool and resource in state government. Different electronic systems streamline and automate processes, provide real-time data, and make DHHS information and many of the services the agency offers more accessible, timely, and customer focused. The landscape of how we move, receive and exchange information is constantly changing and DHHS must keep pace. It is critical that different kinds of data work together effectively across the board to produce real results. DHHS is looking toward the future of how our data systems will change and what can be done now to put new technology in place that will serve Nebraskans well today, tomorrow and in the years to come.

There are seven priorities in this category:

- ▶ Improve Utilization of THERAP
- ▶ Developmental Disabilities Eligibility Determinations
- ▶ Medicaid Client Eligibility and Enrollment Solution
- ▶ Medicaid Management Information System Replacement Project
- ▶ Veterans' Homes Electronic Health Record and Pharmacy Management Software
- ▶ Behavioral Health Centralized Data System
- ▶ Enterprise Technology Delivery

Increasing Operating Efficiencies and Improvements

The existence of a solid Department foundation is a determinant of future success. A focus on additional improvements, efficiencies, and reduction in regulatory complexities will strengthen the agency's culture, enhance quality and performance, and help make the agency even better positioned to serve Nebraskans.

There are seven priorities in this category:

- ▶ Public Health Accreditation
- ▶ LPN/RN Licensure Application Improvements
- ▶ Central Nebraska Veterans' Home
- ▶ Employee Recruitment and Retention
- ▶ Improve Flow and Decrease Wait List at Lincoln Regional Center
- ▶ Maintain and Improve ACCESSNebraska Performance for Economic Assistance Programs
- ▶ Single Audit Corrective Action Plans

DHHS will work toward and show progress on these 25 priority initiatives. Nebraskans can be proud of the improvements made by the DHHS team so far, and can be confident that this Agency continues its commitment to helping people live better lives.

Introduction

This business plan will guide the current and future work of the Department of Health and Human Services through June 2017. The focus is on real improvements and sustainable progress, resulting in better lives for Nebraskans. While this does not represent the full work of the Department, its purpose is to present the Department's top priorities as they appear today, aware that others may emerge as we move forward. This plan outlines 25 priority initiatives, defines goals, and charts progress as we continue our efforts to improve services and effectively manage resources.



DHHS Overview

Organizational Review

The Department of Health and Human Services provides important and oftentimes life-sustaining services to Nebraskans. Our mission, *"Helping people live better lives,"* provides the motivation to effectively provide these services and make a difference in the lives of hundreds of thousands of people.

DHHS is Nebraska's largest state agency, responsible for nearly one-third of state government in terms of employees and budget.

Agency-wide values guide employees in achieving this mission and effectively implementing the state- and federally-mandated programs and services that

assist Nebraskans. These values include: constant commitment to excellence, high personal standard of integrity, positive and constructive attitude and actions, openness to new learning, and dedication to the success of others.

Leadership and Management

The Chief Executive Officer, who is appointed by the Governor and confirmed by the Legislature, directs the responsibilities and work of the Department with direct oversight of six divisions and eight operational areas.

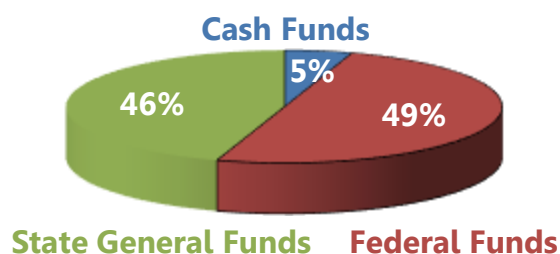
The six Division Directors, who are appointed by the Governor and confirmed by the Legislature, report to the CEO. The divisions are Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long-Term Care, Public Health, and Veterans' Homes.

Operational areas include Communications and Legislative Services, Information Systems and Technology, Legal Services, Human Resources and Development, Support Services, Internal Audit and Operations Consulting. In addition, a Chief Financial Officer reports to the CEO and oversees Financial Services.

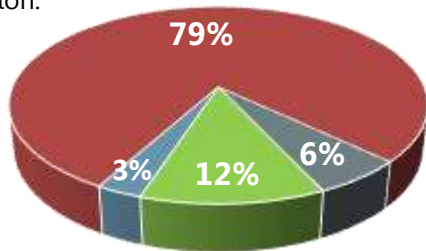
The 2015 State of Nebraska Personnel Almanac reported 5,469 full-time equivalent employees for DHHS at the end of December 2014. This includes staff in all offices and the 10, 24-hour facilities located across the state.

Expenditures to support programs and services for Fiscal Year 2015 totaled \$3,074,734,159.

The funds came from three sources: federal funds (49 percent), state general funds (46 percent), and cash funds (5 percent).



In Fiscal Year 2015, more than three-fourths (79 percent) of DHHS expenditures were for cash benefits and services to Nebraskans. Six percent was for state-operated services, such as the Beatrice State Developmental Center, three Regional Centers, four Veterans' Homes and two Youth Rehabilitation and Treatment Centers. Three percent was to provide population-based services, including public health prevention and promotion activities. Twelve percent went for administrative services, including the functions of determining eligibility for agency programs, the protection and safety of children, and service coordination.



- Client Benefits and Services
- State Operated Services
- Administrative Services
- Population Based Services

The two guiding principles for managing the Department's budget are transparency and accountability. As a public agency, DHHS has a responsibility to use citizens' tax dollars wisely and to uphold the highest standards of fiscal integrity.

Division of Behavioral Health

SHERI DAWSON, DIRECTOR

The Division of Behavioral Health is the behavioral health authority for the state and directs the administration and coordination of the public behavioral health system to address prevention and treatment of mental health and substance use disorders. The Division's mission is to provide leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

The Division provides funding and contract management to six behavioral health regions and a variety of providers to ensure community-based mental health and substance abuse prevention and treatment services are available.

The Division operates three Regional Centers in Lincoln (LRC), Norfolk (NRC), and Hastings (HRC). Combined, they serve about 400 people. Services include general psychiatric services for those committed by a board of mental health or ordered there by a court (LRC), as well as treatment to sex offenders (NRC, LRC). Services also include Psychiatric Residential Treatment Facility treatment for substance use disorders for young men (HRC) and for young men who have sexually harmed (LRC/Whitehall). Most of the young men served have been involved in the criminal justice system.

An Office of Consumer Affairs focuses on recovery initiatives, planning, research, and advocacy for behavioral health consumers.

The Division provides the Nebraska Network of Care, an online resource for people with mental illness, their caregivers, and service providers that lets people access information about issues such as treatments, resources and diagnoses, and wellness recovery action plans. Consumers can also choose to communicate directly with other participants and to organize and store their own personal health information.



Division of Children and Family Services

DOUG WEINBERG, DIRECTOR

The Division of Children and Family Services provides child and adult protective services, economic assistance services, and juvenile rehabilitation and treatment services.

Child protective services include prevention activities, investigations of child abuse and neglect, in-home services to keep children at risk of abuse and

neglect safely with their parents, domestic violence services, foster care and adoption services for children who cannot safely live at home, and transitional services designed to assist and promote self-sufficiency for youth preparing for adulthood. Services are organized into five service areas geographically aligned with judicial districts. Adult protective services investigate reports of vulnerable adults who have been abused, neglected or exploited, intervene when maltreatment is confirmed, and connect individuals with the supports and services needed.

Economic assistance programs are a safety net for more than 242,000 Nebraskans and include programs such as Supplemental Nutrition Assistance Program (SNAP); Employment First education and job training; Aid to Dependent Children; Aid to the Aged, Blind and Disabled; refugee resettlement; energy assistance; child care subsidy; as well as child support enforcement.

The DHHS Office of Juvenile Services serves about 140 youth in two Youth Rehabilitation and Treatment Centers in Kearney and Geneva, which are accredited by the American Correctional Association. With the addition of a new administrator at the YRTC-Kearney, processes and structure are being reviewed and could lead to an additional initiative.

Division of Developmental Disabilities

COURTNEY MILLER, DIRECTOR

The Division of Developmental Disabilities administers publicly-funded developmental disability services to approximately 5,000 individuals within a community-based setting. An additional 4,000 individuals are waiting on the registry of unmet need for a service. An added 115 people live in five DHHS intermediate care facilities for persons with developmental disabilities (ICF/DD) in Beatrice.

The Division of Developmental Disabilities strives to support the choices of individuals with disabilities and their families by promoting and providing flexible, quality, member-driven services and supports within communities, and valuing our community connections with an emphasis on looking at a person's strengths and gifts.

The Division administers three home and community-based services (HCBS) Medicaid waivers

as well as state-funded services. Services are provided based on each person's identified needs, state and/or federal guidelines and, when applicable, the availability of funds. While some services are delivered directly by DHHS, most services are delivered through a large network of individual and agency contracted providers. The Division collaborates with other agencies, providers, families and self-advocates, increasing opportunities for individuals with developmental disabilities to access the most integrated, least restrictive services and supports.

A clinical team is available to provide dental, nutritional, medical and psychiatric consultations, and support to eligible individuals in the community at large. Additional specialized staff provide training across the state in functional behavioral assessment, physical and nutritional management, and other topics relevant to supporting people with developmental disabilities.



Medicaid and Long-Term Care

CALDER LYNCH, DIRECTOR

The Division of Medicaid and Long-Term Care (MLTC) includes Medicaid and the Children's Health Insurance Program, Home and Community Services for Aging and Persons with Disabilities, and the State Unit on Aging.

Medicaid pays for health care services to eligible elderly, persons with disabilities, low-income pregnant

women, and children and their parents, covering more than one in every 10 Nebraskans.

The Division also administers non-institutional home and community-based waivers including the aged, adults and children with disabilities, and infants and toddlers with special needs.

The State Unit on Aging collaborates with public and private service providers to ensure a comprehensive and coordinated community-based services system that assists people to live in a setting they choose and continue to be contributing members of their community. The Unit partners with Nebraska's aging network that includes eight Area Agencies on Aging.

The Division also includes Medicaid eligibility determination, policy, provider enrollment, rate setting and reimbursement activities, claims processing, and program integrity activities.



Division of Public Health

COURTNEY PHILLIPS, ACTING DIRECTOR

The Division of Public Health brings together all the elements of public health within the Department of Health and Human Services. It's committed to ensuring Nebraskans receive safe, effective, quality care as well as helping them live a healthy lifestyle throughout their entire lives.

The Division has two sections. One is Health Licensure and Health Data and the other is Community and Environmental Health. Health Licensure and Health Data is responsible for epidemiology and informatics; licensure, regulation and investigations of health-related professions, occupations, facilities and services; public health preparedness and emergency response;

and vital records. Community and Environmental Health is responsible for community and rural health planning, environmental health, health promotion and lifespan health services.



Division of Veterans' Homes

JOHN HILGERT, DIRECTOR

Providing outstanding care and service to Nebraska veterans is the top priority for the Division of Veterans' Homes. The Division operates four state veterans' homes located in Bellevue, Grand Island, Norfolk, and Scottsbluff. Construction will soon begin on a home to replace the Grand Island facility to be located in Kearney.

Employees at all four Nebraska's Veterans' Homes provide a helping hand to our member veterans every day, and treat the men and women who have served in the U.S. Armed Forces with the respect they deserve.

With a total capacity of 637 beds, the four Veterans' Homes provide a variety of medical, nursing and rehabilitative services tailored to the needs of their members. Services range from assisted living care for members able to care for themselves to skilled nursing care. Members' health care services are administered by dedicated nurses, physicians, dietitians, occupational therapists, speech therapists, physical therapists and other professionally trained personnel.

All four homes have a proud history of serving veterans.

General Operations

DHHS has eight operational sections that provide specialized expertise and support to all divisions. The daily work of these areas impacts the success of every

employee in carrying out the DHHS mission of helping people live better lives.

Communications and Legislative Services manages public, internal and stakeholder communications including media relations, outreach and publicity/promotion efforts, the DHHS website, social media, newsletters, video productions and graphic design; legislative activities; and the DHHS Helpline which responds to questions and concerns related to DHHS programs and services.



Financial Services provides support through budget development and monitoring, state and federal report preparation, program evaluation, accounting transactions, revenue collections and monitoring, grant and contract support, claims processing, research, financial and program analysis, and cost allocation.

Human Resources and Development (HRD) provides personnel support to Department employees and managers across the state, including staffing requests for position reclassification and salary grade adjustments; analysis of staffing plans; payroll, workers' compensation and benefits; employee and labor relations; employee recognition, recruitment, selection, placement, retention and succession planning; and the Employee Assistance Program. In addition, HRD is responsible for training coordination, staff development, leadership and supervisory training, and meeting and team facilitation.

Internal Audit evaluates, identifies, and assists areas in need of improvements with their current

processes and procedures, and provides guidance and information to DHHS staff regarding procedures, operational controls, regulations, internal controls, and best practices. Internal Audit also maintains audit records and provides a DHHS point of contact for the coordination of all audits, reviews, attestations, or site visits in which a federal or state official is reviewing one or more DHHS programs or grants.

Information Systems and Technology provides planning and project management, implementation and ongoing support of information systems, network and hardware support including procurement and installation, local area network management and maintenance, and internal help desk support for both system-specific and agency-wide questions and concerns.

Legal Services provides legal advice to DHHS divisions; represents DHHS in administrative hearings and court cases; interprets state and federal laws and regulations; drafts and reviews legislation, rules and regulations, contracts and other documents.

Operations Consulting is an internal consulting team that identifies, develops, implements, and evaluates business practices throughout DHHS for efficiency and effectiveness with a concentration on improved services, reduced costs and streamlined processes. Work may also impact other state agencies and external stakeholders. Operations Consulting provides additional assistance to DHHS program staff to implement corrective action plans.

Support Services provides technical assistance and support in purchasing; equipment inventory; surplus property; vehicle management; risk management; land-based telecommunications; language line; Spanish translation; office space planning, leasing, space management, office set-up, and facility engineering; Americans with Disabilities Act (ADA) compliance review and design; records management; security and emergency planning; building access control, word processing, centralized scanning, property insurance administration, distribution of mail; forms and supply management, contractual services and sub-awards, and security administration for EnterpriseOne, the state's accounting, procurement and payroll system.

DHHS Priorities

The Department has identified 25 priorities that will result in real improvements, sustain current progress, and help Nebraskans live better lives. They are grouped under five categories that span the work of the agency:

- ▶ Integrating Services and Partnerships
- ▶ Promoting Independence through Community-Based Services
- ▶ Focusing on Prevention to Change Lives
- ▶ Leveraging Technology to Increase Effectiveness
- ▶ Increasing Operating Efficiencies and Improvements

Integrating Services and Partnerships

Heritage Health (Medicaid Managed Care)

BACKGROUND

Nebraska Medicaid currently provides health care coverage for approximately 231,000 individuals each month at an annual cost of approximately \$2 billion. The Nebraska Medicaid Managed Care Program, which was first implemented in Nebraska in July 1995, initially provided physical health benefits to Medicaid members in three counties. Today, approximately 80 percent of individuals who qualify for Medicaid receive their physical health benefits through managed care and almost all Medicaid members receive their behavioral health benefits through managed care. Physical health services are provided by three managed care organizations (MCOs) and behavioral health services are provided by a separate contractor.

In October 2015, the Department released a request for proposal (RFP) to select qualified MCOs to provide statewide integrated medical, behavioral health, and pharmacy services to almost all Medicaid members. This program will be called Heritage Health. DHHS awarded three MCO contracts in April 2016 and the program will begin operations on January 1, 2017.

In a risk-based managed care delivery system, MCOs are responsible for the management and provision of specific covered services. For this responsibility, they receive a set amount per member each month as payment from DHHS. Having one health plan responsible for the full range of

services for a member encourages investment in more cost-effective services to better address the health care needs of the whole person.

Heritage Health will integrate the health care for groups of enrollees who were previously excluded from participation in the Department's physical health managed care program, but who received their behavioral health services through the Department's behavioral health managed care contractor. These groups include individuals with Medicare as their primary insurance, individuals who are enrolled in one of DHHS' home and community-based waiver programs for individuals with physical disabilities or developmental disabilities, as well as individuals who live in long-term care institutional settings such as nursing homes or intermediate care facilities for people with developmental disabilities.

While these individuals will have their physical, behavioral, and pharmacy health services coordinated by their Heritage Health plan, the administration of their long-term supports and services (such as their institutional care or in-home care) will continue to be administered as it is today while DHHS works with stakeholders to study reform for that system.



The Heritage Health RFP requires contracted MCOs to report comprehensively on a wide variety of nationally recognized health measures. Nebraska Medicaid will partner with its sister Divisions to use this reporting to design and implement quality improvement programs, with the aim of establishing Nebraska as a performance leader in a broad range of health measures for children and adults. Furthermore, quality measure reporting will lead to the establishment of performance goals tied to financial incentives for measures specific to the needs of Nebraska's Medicaid members.

Heritage Health will also require a significantly more robust care management strategy focused on the early identification of members who require active care management. Once a member is identified for active

care management, the goal of the program is to ensure that the member receives the appropriate combination of services and that costly episodes of care, like emergency room visits or hospital admissions or readmissions, are prevented.

The RFP also requires that Heritage Health MCOs address the social determinants of health in their health risk assessment and care management strategy. There are clear connections between social factors like housing, food security, and education with health outcomes. All MCO staff must be trained on how social determinates affect members' health and wellness, including issues related to housing, education, food, and trauma. Staff must also be trained on, and have access to, information regarding Nebraska's community resources and making referrals to these agencies and other programs that are helpful to members.

Heritage Health MCOs will be required to maintain robust provider networks which include hospitals, physicians, specialists, pharmacies, mental health and substance use disorder providers, federally qualified health centers and rural health clinics, and allied health providers. The development of these provider networks in the state will increase access to services, including behavioral health services to at-risk youth. The MCOs' network of providers must offer an appropriate range of preventive, primary care, specialty, and recovery-oriented services that meet specific provider access standards. Heritage Health MCOs will also support and promote patient-centered medical homes that provide comprehensive, coordinated health care through consistent, ongoing contact with members.

GOALS

Managed care was implemented in Nebraska to improve the health and wellness of Medicaid members by increasing their access to comprehensive health services in a cost-effective manner. As behavioral health services are added to the physical health delivery system, additional goals for all members include decreased reliance on emergency and inpatient levels of care by providing clients with evidence-based care options that emphasize early intervention and community-based treatment. MLTC also anticipates

that integrated physical and behavioral health managed care will achieve the following outcomes:

- ▶ Improved health outcomes
- ▶ Enhanced integration of services and quality of care
- ▶ Emphasis on person-centered care, including enhanced preventive and care management services
- ▶ Increased access to evidence-based behavioral health services to at-risk youth
- ▶ Reduced rate of costly and avoidable care
- ▶ Improved financially sustainable system

PROGRAM STRATEGY

Developing and implementing Heritage Health involves the following strategies and activities:

Complete the procurement process. DHHS released the Heritage Health RFP in October 2015. The Department determined the proposal teams, and developed the criteria and training materials for the evaluators. DHHS staff evaluated proposals and recommended to leadership the bidders that should receive a contract. The final step in this process is contract negotiation with the MCOs.

Contract with enrollment broker. DHHS released an RFP in late December 2015 to procure an enrollment broker (EB). Starting in September 2016, the successful EB will assist Medicaid enrollees with Heritage Health MCO and primary care provider selection. On or before January 2018, the EB will also work with DHHS to determine the monthly capitation payment each MCO should receive and calculate any needed payment recoupments.

Ensure operational readiness. Once DHHS has awarded contracts with the MCOs, it must ensure that each MCO is operationally ready. A readiness review will be completed before the MCOs can begin operations. If any issues are discovered during the readiness review process, the MCOs must implement corrective measures to resolve the issues before operations can begin.

Implement program enhancement initiatives. DHHS has described several program enhancements that it will work with the MCOs to implement. These will include, but are not limited to:

- ▶ Establishing a Behavioral Health Integration Advisory Committee to facilitate the integration of physical and behavioral health services and promote the successful transition for members and providers
- ▶ Involving community organizations in outreach, education and service delivery to ensure that members' health and social needs are met
- ▶ Working with the MCOs to design and implement robust reporting of performance metrics, including quality of care and member and provider satisfaction
- ▶ Establishing a quality committee to include providers, MCO quality experts and DHHS clinical leadership to enhance the MCOs' quality initiatives and determine performance incentives
- ▶ Working with the MCOs to advance patient-centered medical home strategies
- ▶ Completing annual operational reviews of the MCOs
- ▶ Increasing access to behavioral health services to at-risk youth
- ▶ Designing financial incentives and penalties to ensure compliance with key operational provisions and incentivize strong performance on program goals
- ▶ Establishing an Administrative Simplification Committee with state, provider, and MCO representation to identify and implement common practices and forms to streamline providers' administrative experience
- ▶ Working with the MCOs to establish and expand value-based purchasing arrangement

DELIVERABLES

| Deliverable | Target Completion |
|------------------------------|----------------------------------|
| RFP release | October 21, 2015 |
| Proposals due | January 5, 2016 |
| Evaluation period | January 12 – 29, 2016 |
| Intent to award announcement | February 5, 2016 |
| MCO contract award | April 2016 |
| EB contract award | April 2016 |
| MCO readiness reviews | July 2016 |
| MCO selection and enrollment | September – December 2016 |
| Heritage Health start date | January 2017 |

Behavioral Health System of Care for Children, Youth and Families

BACKGROUND

System of Care is a framework for integrating mental health services and supports for children and youth who have a serious emotional disturbance, and their families, through a collaboration across and involving public and private partners, families and youth.



A System of Care improves access to a full array of coordinated community-based services and builds on the strengths of individuals. It addresses each person's cultural and linguistic needs. It helps children, youth, and families function better at home, in school, in the community, and throughout life.

This approach has gained wide acceptance particularly for children with serious and complex mental health needs, and who may be involved in multiple systems.

States and communities that have implemented the System of Care approach have reported changes, including:

- ▶ Increase in school attendance and school performance
- ▶ Decrease in average age of first system contact
- ▶ Decrease in cost per youth receiving services
- ▶ Increase in percent of youth and young adults living in home settings

GOALS

Access to appropriate and effective behavioral health services will increase, particularly for individuals with complex needs, by integrating the System of Care across DHHS divisions and programs. The program will partner to develop a common language for care, unify policies and practices including family-centered care, and avoid duplication of services for children and their families.

PROGRAM STRATEGY

Behavioral Health will Initiate the first phase of Children's System of Care, and implement an action plan through developed partnerships to include formation of the system structure, initiation of standing work teams, and development of regional System of Care leadership groups.

DELIVERABLES

| Deliverable | Target Completion |
|--|-------------------|
| Staff assembled, Leadership Board, Implementation Committee and Standing Work Teams convened | September 2016 |
| Cross-system map of services/supports, eligibility, funding sources, policies, practices and regulations completed | September 2016 |
| Mechanism for public/private partnerships in carrying out implementation action steps (contractual/MOUs) established | June 2017 |
| Mechanism established for cross-system monitoring of SOC services and supports | June 2017 |

Family-Focused Case Management in Economic Assistance

BACKGROUND

A long-standing criticism of government at both the state and federal levels has been the nature of public financial support. Too many funding silos across too many seemingly independent agencies make success in social services a difficult challenge. This is especially true in the area of intergenerational poverty and self-sufficiency. Compounding the problem is the fact that the barriers to sustainable employment often extend far



beyond education and job training. To successfully support children and families, break the cycle of intergenerational poverty, and reduce the potential for subsequent child abuse and neglect, policy makers must leverage funding and programming across a number of state, local, federal, and private agencies in line with the Governor's priorities for efficient and effective government that improves public safety and well-being.

In Nebraska, opportunities for closer collaboration between child welfare, Aid to Dependent Children through the Temporary Assistance to Needy Families (TANF) block grant, Supplemental Nutritional Assistance Program (SNAP), child care subsidies, child support enforcement, and the private sector exist within the Division of Children and Family Services. Opportunities also exist to leverage resources across other federal, state, and private funding streams.

Introducing family-focused case management to families involved in Nebraska's public assistance programs represents a bold step in this direction. One possible approach would be to provide family-focused case management to recipients of Nebraska's Aid to Dependent Children's (ADC) program through the state's Employment First Program. The goal of this program is to promote sustainable employment at a reasonable wage that leads families to self-sufficiency.

Family-focused case management emphasizes the family unit as a whole, not just increasing the job readiness of potential wage earners through job skills training and education. The goal is to eliminate the barriers to long-term, sustainable employment that many families face.

Barriers to sustainable employment can include any one or combination of the following:

- Substance use and/or addiction
- Adult or child mental health issues
- Adult or child physical health issues
- The need to care for younger siblings or children
- The need to care for older adults
- Potential incarceration for past due child support
- Homelessness
- Child care issues
- Lack of extended family supports
- Lack of community supports
- Lack of social capital and positive peer support
- Insufficient education
- Lack of job training

GOALS

The Division of Children and Family Services (CFS) introduces family-focused case management to Economic Assistance programs to promote self-sufficiency and sustainable employment to reduce the number of individuals and families re-entering public assistance programs.

This intensive family-focused case management can provide long-term positive results for the family including, but not limited to, sustainable employment and improved parenting.

PROGRAM STRATEGY

CFS will incorporate family-focused case management in its new Employment First contract by creating partnerships with contractors, case managers, and clients to integrate services. Employment First is the Division's workforce services program that provides ADC (TANF) recipients in Nebraska with education, training, and other services to assist them in achieving sustainable employment.

The practice of family-focused case management builds connections throughout the community in an effort to address one or more of these barriers. Connections can include other economic assistance programs, one-stop job centers, physical and mental

health programs and providers, other state agencies, non-profit community resources and agencies, faith-based organizations, extended family members, and positive peer influences such as local support groups.

The key to success is the careful coordination of all potential sources of support, and a comprehensive inventory of all available supports at the case manager's fingertips, regardless of funding stream or responsible governmental entity.



A family-focused case management pilot or program in Nebraska would involve embedding economic assistance as well as protection and safety case workers in the Employment First office to enhance communication and coordination of an array of services to help clients reach self-sufficiency. The initial goal of the family-focused case management is triage. A multi-disciplined team would staff the case. Once the most significant barriers are identified, the case management team can prioritize potential interventions and supports in a comprehensive case plan and subsequently reach out to community resources and supports to make appropriate referrals and contacts. The case management team will also work with the family to identify activities and/or support groups that will provide positive peer influence and social capital.

At the same time, family-focused case managers work closely with all family members to build a level of trust and confidence with the family.

Finally, case managers work with families to ensure appropriate connections are made in a timely and consistent manner. Case managers also frequently follow up in team meetings with the family and community agencies to develop assistance and interventions aimed at moving clients to self-sufficiency.

Benefits to the state include reduction in TANF, SNAP, child care assistance, and Low-Income Home Energy Assistance Program (LIHEAP) recipients, reduced arrearages in child support payments, and reduced instances of child abuse and neglect.

DELIVERABLES

| Deliverable | Target Completion |
|---|-------------------|
| Development of pilot program | May 2016 |
| Commencement of new statewide Employment First contract with Family Focused Case Management pilot | July 1, 2016 |
| Review progress of pilot program | December 2016 |
| Evaluate pilot program to assess expansion to other areas of the state | June 2017 |

Cross-Division Solutions Team

BACKGROUND

Department of Health and Human Services Chief Executive Officer developed the Cross-Division Solutions Team (CDST) to find solutions for individuals and/or families who have complex issues and who may need services or supports from multiple Divisions within DHHS. Prior to this team, Divisions did not have a direct venue to work together on cases. The Divisions of Behavioral Health, Children and Family Services, Developmental Disabilities, and Medicaid and Long-Term Care, as well as Legal Services and Internal Audit meet weekly to review these cases. The Division of Public Health is involved as needed. Referrals for the CDST come from the DHHS CEO, the Division Directors, Ombudsman's office, senators' offices, and other system partners.

GOALS

- Evaluate each individual's and/or family's complex needs to determine how the Divisions can work together to increase accessibility
- Identify system gaps and make recommendations resulting in better outcomes
- Increase participant knowledge on available services provided within the Department

PROGRAM STRATEGY

Key individuals from each Division have been chosen by the various Division Directors to be members of the Cross-Division Solution Team (CDST). The members of the CDST meet weekly to review the case referrals, and as a whole, develop solutions to meet the needs of individuals and families. The members take a "can do" approach and think out of the box without going outside of the Department rules and regulations.

DELIVERABLES

| Deliverable | Target Completion |
|---|-------------------|
| Consistent Division participant representation | January 2016 |
| Program representatives including Magellan presented on eligibility and benefits | January 2016 |
| Engagement and cross-divisional collaboration | Ongoing |
| Broader analysis of issues and how they can be addressed with agency resources as a whole | Ongoing |
| Identify gaps in the system | Ongoing |
| Individual and Family outcomes | Ongoing |
| Standardized referral process | March 2016 |
| Memo to internal employees | March 2016 |
| Data collected on program eligibility status of each individual referred | Ongoing |

Promoting Independence through Community-Based Services

Developmental Disabilities Home and Community-Based Waivers, and Community-Based Transition Plan

BACKGROUND

Two of the Division of Developmental Disabilities' (DD) Medicaid adult waivers are in the renewal process and negotiations are underway with the Centers for Medicare and Medicaid Services (CMS) to ensure that the waivers comply with all federal regulations, and afford optimal services for Nebraskans with developmental disabilities. DD has requested an extension to respond to questions and address the gaps in the

waiver applications, and will resubmit these waiver applications as well as the DD children's waiver application to ensure consistency in administration of the waiver programs.

The federal mandate is that the state Medicaid agency retain ultimate administrative and financial authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

The waivers lack adequate Division of Medicaid and Long-Term Care (MLTC) oversight and Developmental Disabilities (DD) will be correcting this critical administrative and structural gap through the waiver renewal process. One critical example of the lack of oversight is that DD has closely managed the utilization and corresponding financial performance of its waivers with little-to-no oversight by MLTC. Waiver budget cycles are not aligned with the state's fiscal year and waiver services are underutilized.

We will be working closely with Medicaid leadership to tighten our fiscal management of the waivers and ensure that we maximize our Medicaid program to benefit Nebraskans with developmental disabilities.

An important federal rule took effect on March 17, 2014. There are three parts to the new Rule, 42 CFR 441.301: The person-centered planning process, which increases the person's input in how services are planned and what is included in the plan of care; conflict-free case management; and home and community-based services settings which increase protections related to where people receive Home and Community-Based Services (HCBS).

GOALS

The goal is to develop and implement DD HCBS waivers focused on person-centered, customer-focused planning, indicate the priority system in Nebraska for waiver funding, indicate the appropriate number of waiver slots available and utilized, and provide CMS accurate information on the waiting list in Nebraska. Regarding the new rule regarding person-centered planning, we will develop and implement a transition

plan that complies with CMS requirements while maintaining our service array and provider network.

PROGRAM STRATEGY

The Division of Developmental Disabilities will ensure compliance of CMS regulations on the waiver process to accurately identify and articulate the service delivery for people with developmental disabilities in Nebraska, and build on best practices in the nation to serve people in the least restrictive community setting. We will meet with internal and external stakeholders for ideas and strategy development to build the best transition plan possible for Nebraska, and draft an amended transition plan and publish it for public comment.



DELIVERABLES

| Deliverable | Target Completion |
|--|------------------------------|
| Submitted DD HCBS waivers to CMS | September 30, 2015 |
| Self-assessment by CDD providers only for Transition Plan | November 2015 |
| Statewide meetings with staff and providers for Transition Plan | December 2015 |
| Received questions about the waiver submissions | December 2, 2015 |
| Submitted temporary extensions on adult waivers | December 4, 2015 |
| Provide responses to questions from CMS | Ongoing |
| Engage in a corrective action plan as needed | Ongoing |
| Simplify Personal Focus Worksheet for Transition Plan to ensure people a voice by utilizing best practices and input from pilot project | January 2016 |
| Implement a new level of care instrument that is best practice | January 2016 |
| Stakeholder engagement | February 2016/ongoing |
| Add valid statistical sample for QI measure | March 2016 |
| Assessment of statistical stratified sample of residential and day service programs by service coordination with providers for Transition Plan | March 2016 |
| Post final Transition Plan assessment findings | April 2016 |
| Schedule/hold public comment on Transition Plan | April 2016 |
| Rewrite our waivers utilizing best practice and a national expert in the field of DD waivers | October 1, 2016 |

Developmental Disabilities Registry of Unmet Needs

BACKGROUND

All individuals determined eligible for developmental disabilities services are entered into this Registry database through the completion of a comprehensive demographic and risk assessment instrument. The purpose of the Registry is to identify the service needs of individuals deemed eligible for Division of Developmental Disabilities services. This includes a risk assessment to prioritize those in need of residential placement or identify the need for other critical

services, whether they are eligible for services under the Medicaid DD waivers or the DD Service Authorization entitlement program.

GOAL

The purpose of the Registry is to identify the service needs of individuals deemed eligible for Division of Developmental Disabilities services, and, through the Registry, track those services by funding source.

PROGRAM STRATEGY

The Division of Developmental Disabilities will review all individuals on the Registry of Unmet Need to ensure that the individuals meet residence requirements and still desire services, encourage all individuals over 18 years of age to apply for Medicaid since they may no longer have an ability to pay, offer service coordination to individuals listed on the Registry, and work with individuals receiving service coordination to access other services inside and outside DHHS including programs such as the Program of All-Inclusive Care for the Elderly (PACE), Personal Assistance Service (PAS), and Aged and Disabled (AD Waiver).

DELIVERABLES:

| Deliverable | Target Completion |
|---|---------------------|
| Improved number of people getting the correct services from the correct agency at the correct time in their lives | June 2016 |
| Better identification of service needs of individuals deemed eligible for DD services | June 2016 |
| Track services by funding source and utilize data for future budget considerations | January 2017 |
| Improvement in identifying individuals in need of residential placement and other critical services | June 2017 |
| More complete and useful Registry | June 2017 |

Long-Term Services and Supports (LTSS) Redesign Project

BACKGROUND

Over the past several years, the Division of Medicaid and Long-Term Care (MLTC) has engaged stakeholders in conversations regarding the delivery of long-term services and supports (LTSS). Those initial conversations

resulted in a plan to implement managed LTSS by integrating the services into risk-based contracts with managed care organizations. MLTC has revisited those plans and is opening a broader dialogue with stakeholders regarding a more comprehensive redesign of LTSS services in Nebraska. The LTSS redesign project will be a collaborative initiative between MLTC and LTSS stakeholders to evaluate the current LTSS landscape, identify key opportunities for improvement, and redesign the system to meet the future challenges and growing demand for LTSS.

GOALS

The LTSS redesign effort is focused on opportunities for improvement in Medicaid LTSS services, specifically the following goals:

- ▶ Improve the quality of services and health outcomes of recipients.
- ▶ Promote independent living in the least restrictive setting through the use of consumer focused and individualized services and living options.
- ▶ Strengthen access, coordination and integration of care through streamlined LTSS eligibility processes and collaborative care management models.
- ▶ Improve the capacity to match available resources with individual needs through innovative benefit structures.
- ▶ Streamline and better align the programmatic and administrative framework to decrease fragmentation for clients and providers.
- ▶ Refocus and rebalance the system in order to match growing demand for supports in a sustainable manner.

PROGRAM STRATEGY

Developing and implementing the LTSS redesign project involves the following strategies and activities:

Releasing the LTSS redesign concept paper. In January 2016, MLTC released a concept paper with the general principles to guide the LTSS redesign project. MLTC has identified several current components of the Medicaid LTSS system that present opportunities for focused effort and improvement that are highlighted

in the concept paper. These areas are interrelated and, when addressed together, have great potential to offer improvement in long-term care and choice for the Nebraska LTSS population, help achieve compliance with federal requirements, promote administrative efficiencies, and maximize program resources.

Engage LTSS Redesign Technical Assistance

Consultant. MLTC will complete a competitive procurement to select and engage a technical assistance consultant to work with the Division to gather stakeholder input, study best practices, and develop recommendations and work plans for the redesign effort.

Engage with stakeholders on the LTSS redesign.

MLTC and the contractor will solicit input and feedback from individuals receiving LTSS, advocacy organizations, providers, managed care organizations, care coordination agencies, legislators, and any other interested members of the public. This feedback will be reflected in the final LTSS redesign plan.

Develop LTSS redesign plan. From the concept paper feedback and the work of the LTSS consultant, MLTC will release a substantive LTSS redesign proposal by the end of 2016. This redesign proposal will outline a concrete plan for improving LTSS in Nebraska for the state's Medicaid clients and providers.

Begin implementation of program improvements.

After MLTC receives feedback from its stakeholders on the LTSS redesign plan, the opportunities for improvement identified will begin to be implemented in 2017.

DELIVERABLES

| Deliverable | Target Completion |
|---------------------------------------|-------------------|
| Initial concept paper | December 2015 |
| RFP release for consulting contractor | March 2016 |
| Contract award | May 2016 |
| Stakeholder meetings | July 2016 |
| Release of LTSS redesign plan | Late 2016 |
| Implementation of changes | Beginning 2017 |

Increasing Access to Evidence-Based Community Treatment Services for At-Risk Youth

BACKGROUND

Nebraska Medicaid will be growing its behavioral health service array over the next year to provide access to evidence-based services directed toward at-risk youth. In 2015, the Nebraska Legislature passed LB 500. This bill requires the Department to submit a Medicaid State Plan Amendment (SPA) to cover multisystemic therapy (MST). MST is an intensive family- and community-based treatment program designed to enhance parental skills and provide intensive family therapy to troubled and delinquent teens which empowers youth to cope with the family, peer, school, and neighborhood problems that they encounter in order to prevent recidivism in the juvenile criminal justice system.

Medicaid is collaborating with the Divisions of Behavioral Health and Children and Family Services, as well as Probation, on the service array.



Nebraska Medicaid has spent the last year researching and will be prepared to submit this SPA. In addition, the Department will also be including coverage for functional family therapy (FFT) in this state plan. Through its research, Medicaid recognized that coverage for FFT is an important component of a comprehensive evidence-based strategy to improve outcomes for these youth.

For FFT, therapists work with all family members to create specific interventions looking at each individual's unique challenges and strengths. The combination of these two services is projected to lead to improvement in outcomes for at-risk youth, reducing out-of-home placements and preventing recidivism in juvenile offenders.

GOALS

The goals of expanding services to at-risk youth are the following:

- ▶ Reducing out-of-home placements
- ▶ Preventing recidivism in juvenile offenders
- ▶ Improving family relationships

PROGRAM STRATEGY

The strategies are:

- ▶ Submit State Plan Amendment. LB 500 requires the Department to submit a State Plan Amendment by May 1, 2016. The Department will work with the Centers for Medicare and Medicaid Services for its approval.
- ▶ Work with the Office of Probation to expand access to these services.
- ▶ Educate the public about service availability.

DELIVERABLES

| Deliverable | Target Completion |
|--|-------------------|
| Tribal notice for SPA sent | January 22, 2016 |
| Draft SPA sent to stakeholders for comment | February 29, 2016 |
| SPA submitted to CMS for approval | April 1, 2016 |
| Implement after CMS approval | Ongoing |

Focusing on Prevention to Change Lives

Prescription Drug Overdose Prevention and Prescription Drug Monitoring

BACKGROUND

The Nebraska Department of Health and Human Services' Division of Public Health identified preventing unintentional drug overdose as a priority area. Recently, DHHS has received two grants to provide more concentrated and coordinated efforts on this issue. The rate of drug overdose deaths in Nebraska has increased, as well as the rate of neonatal abstinence syndrome, and the rate of drug abuse/withdrawal related emergency department visits. The trend is corresponding with the national trend driven by the alarming increase in prescription opioid addiction.

GOAL

The overall goal is to reduce drug abuse/misuse in Nebraska, which can result in death, hospitalization, addiction, and neonatal abstinence syndrome.

PROGRAM STRATEGY

The following strategies are based on the best available evidence from the Centers for Disease Control and Prevention on addressing the prescription drug overdose epidemic by states. Specific measures were examined from the Injury Surveillance system, to assess the health burden of drug abuse/misuse. Items listed below are identified as promising strategies that states can advance to ensure the health and well-being of their residents.

- ▶ Identify and implement ways to increase use of Prescription Drug Monitoring Programs (PDMP), which are state-run databases that track prescriptions for controlled substances and can help improve painkiller prescribing, inform clinical practice, and protect patients at risk
- ▶ Implement and promote evidence-based opioid prescribing standards
- ▶ Expand use of Naloxone, the opioid overdose antidote through expanded access



- ▶ Identify opportunities to increase access to substance abuse treatment

Specific tasks over the coming months for developing and implementing these strategies include the following:

- ▶ **Make the PDMP easier to use and access.** Convene a group of key partners to review and identify barriers to PDMP access and use. Develop and implement a plan to rectify barriers to PDMP access and use. Expand a pool of healthcare professionals permitted to access PDMP data. Support PDMP training efforts in high-burden regions.
- ▶ **Collaborate with the Nebraska Health Information Initiative (NeHII) on the state PDMP.** DHHS will contract with NeHII to hire a trainer to provide those medical professionals authorized to access the system training on how to use the system to improve patient care. NeHII will

also provide DHHS with PDMP data to use for public health surveillance purposes. NeHII will implement enhancements to the PDMP system to expand access to authorized medical professionals.

- ▶ **Conduct public health surveillance with PDMP data and publicly disseminate reports on a regular basis.** Through collaboration with NeHII, DHHS will support improvement to the PDMP infrastructure for its use as a public health surveillance system. Indicators to be calculated from the PDMP data are: increased registration for and use of PDMP, the percent of patients receiving more than an average daily dose of >100 morphine milligram equivalents (across all opioid prescriptions), rates of multiple provider episodes for prescription opioids (five or more prescribers and five or more pharmacies in a six-month period) per 100,000 residents, percent of patients prescribed long-acting/extended-release opioids who were opioid-naïve (i.e., have not taken prescription opioids in 60 days), percent of prescribed days overlap between opioid prescriptions, and percent of prescribed opioid days that overlap with benzodiazepine prescriptions.
- ▶ **Provide education and awareness on expanded access and appropriate use of Naloxone.** Collaborate with medical professional associations to help educate and raise awareness. Communicate new policy with DHHS programs, such as Emergency Medical Services program, DHHS licensure, and other state agencies who can help raise awareness. Discuss with groups effective ways to educate their members and the general public.
- ▶ **Collaborate with the Division of Behavioral Health and the Division of Medicaid and Long-Term Care.** Invite representatives from both Divisions to stakeholder meetings. Identify ways to collaborate on the issue of drug misuse/abuse. Share information with other Divisions on health burden, recent efforts, funding, and other issues.
- ▶ **Develop and adopt opioid prescribing guidelines.** Convene a 'Prescribing Guidelines Committee' of key external stakeholders, including members of relevant professional boards to establish prescrib-

ing guidelines specific to pain management and opioids. Prescribing guidelines specific to pain management will be disseminated to health care professionals.

- ▶ **Pursue capability of utilizing syndromic surveillance data to rapidly identify "hotspots."** Continue collaboration with the syndromic surveillance coordinator to utilize syndromic surveillance data to rapidly identify areas in the state that are experiencing a high rate of drug-related emergency department visits.

DELIVERABLES

| Deliverable | Target Completion |
|--|-------------------|
| Recruit, hire and train two full-time staff positions | January 2016 |
| Review CDC proposed prescribing guidelines | January 2016 |
| Convene prescribing guidelines workgroup | February 2016 |
| Access PDMP data for public health surveillance | November 2016 |
| Begin training physicians and prescribers on access and use of PDMP system | November 2016 |
| Pilot test using syndromic surveillance data to identify "hotspots" | January 2017 |
| Support efforts to train prescribers/dispensers in high burden areas | January 2017 |
| Coordinate efforts to propose opioid prescribing guidelines to professional boards | March 2017 |
| Convene stakeholder workgroup on regular basis | Ongoing |
| Convene PDMP workgroup to address barriers and improve access | Ongoing |
| Support Naloxone education efforts | Ongoing |

Expansion of Alternative Response

BACKGROUND

The Division of Children and Family Services (CFS) implemented an Alternative Response (AR) pilot project on October 1, 2014, in five counties (Scotts Bluff, Hall, Lancaster, Dodge, and Sarpy). Alternative Response is designed to connect families with less severe reports of

child abuse and/or neglect to the supports and services they need in order to strengthen the protective factors that support parents with keeping their children safe and healthy.

AR is one intervention CFS implemented as part of the Title IV-E Waiver Demonstration Project awarded in 2013 by the U.S. Department of Health and Human



Services, Administration on Children Youth and Families (ACYF). As part of the terms and conditions of the demonstration project, the state was required to secure a third-party, independent evaluator to assess the

process, outcomes and costs of the project. The University of Nebraska-Lincoln Center on Children, Families, and the Law (CCFL) was awarded the contract for the program evaluation.

The development of the AR program was a collaborative project with internal and external stakeholders. To obtain feedback from the numerous entities, various AR committees were created:

- ▶ The AR Internal Workgroup is comprised of CFS field staff and administrators who researched AR and drafted the program and practice model. Recommendations from this workgroup were shared with the Director's Steering Committee and the AR Statewide Advisory Committee.
- ▶ The AR Director's Steering Committee representatives include the Foster Care Review Office, Office of Inspector General, Region V Behavioral Health, Lancaster County Attorney, Court Improvement Project, Nebraska Children and Families Foundation, a Child Advocacy Center, Voices for Children, and internal CFS Administrators.
- ▶ The AR Statewide Advisory Committee is comprised of the Director's Steering Committee along with community and family partnering organizations.

CFS utilized the expertise of the members within each workgroup to obtain feedback and generate ideas about how best to develop an AR model for Nebraska

that is even more customer focused. Their participation was vital to the development and implementation of AR. CFS continues to meet regularly with each of these committees to share implementation and program progress.

A family's ability to access timely services within their community is a vital component of AR. In an effort to expand service capacity, CFS continues to collaborate with the Nebraska Children and Families Foundation (NCFF) which leads local efforts aimed at minimizing poverty, homelessness, and child abuse/neglect within communities. Developing and implementing Child Well-Being Communities is one strategy designed to achieve this goal. Child Well-Being Communities utilize the parental protective factor framework to link families to evidence-based, evidence-informed, and promising practice services available in their community to enhance protective factors, and promote family stability and sustainability. Integrating AR efforts with Child Well-Being Community efforts enhances the likelihood of family success and reduces the likelihood a family will need future CFS intervention.



Building service capacity is only one aspect of the overall service array component. Access to flexible funding is another critical component. Purchase cards are available in each pilot site to buy the concrete supports that are often needed by families. As of July 2015, the most prevalent services utilized include Intensive Family Preservation, Family Support, housing-related assistance (rent, cleaning, utilities, and deposits), transportation (motor vehicle repairs, gas, tires, and windshield), food and clothing. Expenditures for

services and concrete supports through December 31, 2015, total about \$86,000. While the utilization of flexible funds for concrete services is less than expected, field staff report tremendous support from community agencies that have delivered supports and services at no cost.

GOALS

The Division of Children and Family Services will expand the delivery of the AR program to assist families with less severe reports of child abuse and/or neglect, and connect to the supports and services they need in order to prevent children from being placed outside the family home due to safety threats.

PROGRAM STRATEGY

CFS will work with the AR Director's Steering Committee, the AR Internal Workgroup and the AR Statewide Advisory Committee to develop recommendations for the phased expansion of AR. Through the partnership with NCFF, CFS will continue to support the development of Well-Being Communities in order to connect families to the sustainable community services and supports needed.

DELIVERABLES

| Deliverable | Target Completion |
|---|--------------------------|
| Implementation of AR occurs in Banner, Cheyenne, Deuel, Garden, Kimball and Morrill counties | January 2016 |
| Finalize Phase II Expansion Plan | February 2016 |
| Implementation of AR occurs in Arthur, Frontier, Chase, Dundy, Grant, Hayes, Hitchcock, Keith, Perkins, Colfax, Red Willow, Stanton, Platte, Madison, Nance, Boone, Howard, Sherman, Greeley, and Valley counties | March 2016 |
| Implementation of AR occurs in Sioux, Dawes, Box Butte, and Sheridan counties | April 2016 |
| Implement Phase II | July-October 2016 |
| Finalize Phase III Expansion Plan | October 2016 |
| Implement Phase III | January 2017 |
| Finalize Phase IV Expansion Plan | April 2017 |
| Implement Phase IV | July 2017 |

Reduction in Out-of-Home Placements of State Wards by Safely Expediting Reunifications

BACKGROUND

Sixty percent of all children served by the Division of Children and Family Services' (CFS) Protection and Safety unit are in out-of-home placements. These include congregate care facilities (7 percent of all out-of-home placements), relative or kinship homes (49 percent), traditional non-relative foster homes (36 percent), and other out-of-home placements such as hospitals, detention centers, and youth rehabilitation treatment facilities (8 percent). While the increase in the proportion of children placed with relative and kinship homes is commendable, the overall percentage of children placed in out-of-home settings is well above national averages.

| | In-Home | Out-of-Home |
|-----------------------|---------|-------------|
| Nebraska | 40% | 60% |
| United States* | 64% | 36% |

* Child Maltreatment Report 2013, U.S. Department of Health and Human Services.

| | Congregate Placement | Non-Relative Foster Home | Relative Foster Home | Other Placement |
|-----------------------|----------------------|--------------------------|----------------------|-----------------|
| Nebraska | 7% | 36% | 49% | 8% |
| United States* | 14% | 46% | 29% | 11% |

* Child Trends analysis of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS), made available through the National Data Archive on Child Abuse and Neglect (2013).

A great deal of research has been completed assessing the long-term impact of trauma experienced by children when they are removed from their parents. Across the country, child welfare agencies are introducing interventions with evidence of effectiveness designed to allow children to safely remain home. These interventions include: Alternative Response, family-based services such as parent-child interaction therapy (PCIT), intensive family preservation (IFP), and Triple P Positive Parenting Program, as well as early childhood home visiting service models. As a result of these new child welfare practices, jurisdictions across the country have reported significant reductions in

the number of child removals with positive outcomes related to child well-being and repeat maltreatment.

In 2008, Nebraska commenced the process of privatizing child welfare. Over the next several years, all but one of the original lead agencies declared bankruptcy or cancelled their contract. As a result, only one service area, the Eastern Service Area (ESA) serving Douglas and Sarpy Counties, has a lead agency – Nebraska Families Collaborative (NFC). The original five-year contract with NFC has received several one-year extensions. The current emergency extension expires June 30, 2016.

GOAL

The Division of Children and Family Services will implement best-practice interventions designed to safely prevent and reduce the number of children in out-of-home placements resulting in improvement of public safety, as well.

PROGRAM STRATEGY

CFS intends to enter into a new sole-source pilot with NFC, which will include a performance-based lead agency program in the ESA with a sub-pilot focused on reducing out-of-home placements.

The new contract will be established as a risk-based or performance-based contract, which clearly aligns the objectives of both parties in that the provider has capital at risk and financially benefits from improved outcomes.

The contract will include a sub-pilot which incorporates a cross-system of care model, focused on providing families with the services and supports they need to safely prevent removals and expedite the reunification process. The sub-pilot will focus on a specific population of children who are either at risk of removal or who are currently in out-of-home care.

Interventions will include coordinated response teams jointly staffed by DHHS and NFC, the development of new 72-hour placement alternatives for short-term, out-of-home placements to provide time for family stabilization, and readily available in-home safety services and interventions. The sub-pilot will be developed and implemented with input from the courts, county attorneys, juvenile probation, and key community stakeholders.

CFS also is exploring the feasibility of implementing other evidence-based programs for the remainder of the state to prevent unnecessary out-of-home placements. This includes a capacity building project with our federal partners to redesign the IFP model in order to improve family functioning and promote child safety. CFS will be engaged in service area-specific assessments to identify the availability of in-home safety interventions and services required to mitigate identified safety threats that, when not addressed, result in out-of-home placements.

DELIVERABLES

| Deliverable | Target Completion |
|---|-------------------|
| Involve IFP Partners for IFP model redesign | February 2016 |
| Service Area-specific assessment (in-home safety services) template developed | February 2016 |
| Service Areas complete assessment | March 2016 |
| Sub-pilot developed and approved | March 1, 2016 |
| Contract negotiations with NFC finalized | March 31, 2016 |
| Aggregate assessments to identify gaps/capacity needs | April 2016 |
| Conduct financial analysis on identified service needs | May 2016 |
| Signed contract with NFC | June 15, 2016 |
| Finalize IFP model/modify contracts to include new service description | June 2016 |
| Pilot implementation begins (NFC) | July 1, 2016 |
| Execute new IFP contracts | July 1, 2016 |
| Modify/execute contracts | July 1, 2016 |

Leveraging Technology to Increase Effectiveness

Improve Utilization of THERAP

BACKGROUND

The Division of Developmental Disabilities entered into a contract with THERAP in 2010, mandating the use of general event record reporting by all specialized DD providers. THERAP is an electronic records and

documentation system used for the planning, documentation, and reporting needs of organizations that support people with intellectual and developmental disabilities in home and community-based services and other settings.



The state procurement process was completed in March 2012, which included the purchase of and access to all THERAP modules for every provider on a per person/per month basis, funded by DHHS. The initial contract is for a four-year period ending in March 2016. The contract provides for two, three-year extensions. The initial procurement indicated that THERAP is a comprehensive online and web enabled Application Service Provider (ASP) model solution designed to meet the needs, business practices, security requirements, and reporting requirements of the Division and supporting agencies, including providers, Division program management-related functions, and federal agencies. DD service coordinators were trained on the Individual Support Plan components in January 2015. The Registry of Unmet Needs, monthly billing caps, and monthly allocations to non-specialized service authorizations were implemented in 2015.

GOAL

The goal is to utilize THERAP to its greatest functionality while evaluating its effectiveness for continued utilization.

PROGRAM STRATEGY

There will be work with the THERAP team to identify areas of success and areas of improvement. This will include engaging internal and external stakeholders while focusing on the needs of the individuals we serve and having access to information in real time to ensure that person-centered planning and informed consent are present in our delivery system.

DELIVERABLES

| Deliverable | Target Completion |
|--|-------------------|
| Edit claims not submitted as payable within 180 days | February 2016 |
| Stop claims outside 180 days for review by DD | February 2016 |
| THERAP will utilize the best practices in the Nebraska Resource Library identified from the Department of Justice Independent expert in the areas of nursing care plans, behavioral support plans, and protocols for risk such as choking, falls, seizures, etc. | March 2016 |
| Provide billing reconciliation in THERAP via 835 files | March 2016 |
| Simplify the service authorization approval process | March 2016 |
| Transition of all Individual Program Plans (IPP) from InfoPath to the Individual Service Plan (ISP) module in THERAP during annual or semiannual review | July 2016 |
| Modify risk contracts to require all risk providers to utilize the health modules in THERAP | July 2016 |
| All agencies approved for exception funding required to utilize the health modules in THERAP | July 2016 |
| Non-specialized providers allowed to bill in THERAP | July 2016 |
| Implement individual and family access for THERAP | September 2016 |
| Waiver eligibility components automated checklist | December 2016 |

Developmental Disabilities Eligibility Determinations

BACKGROUND

Applicants for Developmental Disabilities (DD) services have indicated a lack of understanding about the eligibility process in general, including how to fill out an application, and what documents are needed in order to determine eligibility for DD Services. As a result, applicants gather many documents in excess of what may be needed in order to determine DD eligibility. In addition, DHHS staff have also learned that individuals and families do not have working knowledge of the wide variety of other DHHS or community services that may be available to them and are unaware of how the various programs function and relate to each other. For example, families often assume that DD and Social Security are a single program, and that ineligibility for DD services also affects their eligibility for other programs such as Medicaid and Social Security. By providing information upfront about the eligibility process, requirements, and other resources and services that the individual may be eligible or qualify for, individuals and their families have some assurance relative to other choices about services that might best meet the individuals needs.

GOAL

The goal is to create a more user-friendly application process and ensure an accurate and timely eligibility determination.

PROGRAM STRATEGY

We are striving to create a user-friendly access point to DD to expedite the application handling process and tighten the timeline for DD responsiveness to eligibility determination requests. Staff have been instructed to work closely with applicants to ensure that the most relevant and current information is available to make sound eligibility determinations.

DELIVERABLES

| Deliverable | Target Completion |
|---|----------------------|
| New application template utilizing community experts | January 2016 |
| Notice of Decision with specific reason for denial | January 2016 |
| Get approval for new application and Notice of Decision | January 2016 |
| Streamlined process for eligibility determinations | January 2016 |
| Issue policy for application processing and determinations with timelines | January 2016 |
| Training for eligibility determination processes | January 2016 |
| Monitoring process for application processing | January 2016 |
| Survey for customer satisfaction and issue survey periodically | January 2016/ongoing |
| Fillable online PDF application | February 2016 |
| Publish timeliness of eligibility determinations to CEO | February 2016 |
| Application management process guide for NFOCUS | June 2016 |
| Application management process guide training for NFOCUS | June 2016 |
| Electronic data and tracking system for application process | June 2016 |
| Application in NFOCUS with major release | July 2016 |
| Online application process in ACCESSNebraska | July 2016 |
| System reports to monitor data and processing timelines | July 2016 |
| Evaluate process for continuous quality improvement | June 2017 |

Medicaid Client Eligibility and Enrollment Solution

BACKGROUND

Implementation of the Affordable Care Act (ACA) required significant changes to states' Medicaid eligibility and enrollment systems. Nebraska's current system, Nebraska Family Online Client User System (NFOCUS), has been in use since the 1990s. After considering alternatives, DHHS determined the best way for Nebraska to meet federal eligibility system

requirements was to implement a new Medicaid eligibility and enrollment solution (EES).

In the latter part of 2013, a Request for Proposals (RFP) was issued and evaluated for a system integrator (SI) to implement a commercial off-the-shelf (COTS) based EES. In addition to the Medicaid eligibility system, the RFP also requested services for business process reengineering, communications, organizational change management, systems hosting, maintenance, and operations. In mid-2014 a contract was awarded to Wipro, LLC. Implementation of the new solution is underway with a target go-live date of March 31, 2017. To date, project initiation and project management fundamentals are complete. The project is entering the latter part of the requirements verification phase.

GOALS

Key goals of the EES project include increased automation for eligibility processing, compliance with federal requirements for Medicaid eligibility systems, implementing an efficient, consumer-friendly solution, and utilizing technology that can be further leveraged by DHHS in the future.

PROGRAM STRATEGY

During the planning phase, project fundamentals, such as project governance and project management tools/processes, were established to build a solid foundation suitable for a large-scale project.

The requirements phase consists of three significant activities: requirements verification, business process modeling, and fit-gap analysis.

This phase is crucial as the expected outcome is a clear definition of the solution to be implemented. The goal of the architecture phase is to design not only a cohesive, integrated solution for Medicaid eligibility and enrollment, but also to ensure the solution fits into a broader enterprise architecture vision.

The design phase details how project requirements will be implemented. The development phase implements the solution utilizing output from all prior phases.

When the complete solution is ready, the project will enter its final phase and be deployed for use. Contingency plans will be developed, user training conducted, client and user support systems put in place, and finally, the solution will be deployed for use by clients and eligibility workers.

Following go-live, the system will be monitored and adjusted as required to ensure a quality user experience.

Specific strategies for developing and implementing EES will involve the following:

- ▶ **Utilize a classic system implementation model.** The EES project follows best practices for system implementations with project initiation/planning, requirements analysis, architecture, design, development, test, and deployment phases. The phased model allows for a structured approach while minimizing project risks.
- ▶ **Re-engineer business processes.** Medicaid eligibility and enrollment processes are examined end-to-end and re-engineered to be automated, where practical, consumer friendly, and efficient.
- ▶ **Leverage COTS to build a modern, flexible platform that can be enhanced for future DHHS initiatives.** The COTS procurement allows for compliance with federal requirements, flexibility for other programs, technology that meets industry standards, collaboration with other states, adoption of best practices, and opportunities to find resources skilled in the technology.
- ▶ **Utilize effective project resource model.** The EES project uses a mixed staffing model including state staff, a system integrator (SI), staff augmentation, and independent verification and validation (IV&V) staff to implement the solution. The multiple disciplines provide a diverse set of resources from which to draw expertise and increase the opportunity for success.

DELIVERABLES

| Deliverable | Target Completion |
|---|-------------------|
| Project kickoff | September 2014 |
| Project initiation and initial planning completed | June 2015 |
| Requirements analysis completed | March 2016 |
| Architecture completed | June 2016 |
| Design completed | June 2016 |
| Development completed | December 2016 |
| Test and training completed | March 2017 |
| Go live | March 2017 |
| Post go live stabilization period completed | June 2017 |

Medicaid Management Information System (MMIS) Replacement Project

BACKGROUND

The Medicaid Management Information System (MMIS) is the mechanized claims processing and information retrieval system that the federal government has historically required states to operate as part of their Medicaid program. Nebraska's MMIS was created in 1977 and can no longer meet the demands of a rapidly changing Medicaid environment. The need for expedient programmatic changes and the ability to readily produce actionable information from data are just two of the many improvements necessary to efficiently manage today's Medicaid program.

During 2015, Nebraska Medicaid completed a strategic analysis, which is comprised of alternative, procurement and market analyses. Seven alternatives were initially analyzed, with a mixture of traditional and innovative solutions. Three additional alternatives were then analyzed and a recommended solution was developed.

The market analysis indicated the vast majority of state Medicaid agencies have traditionally utilized one of two solutions by which to operate their MMIS – either as a self-administered system with in-house operations (as is currently done in Nebraska) or by contracting with an entity to provide and maintain a system and conduct operations, often referred to as a fiscal-agent arrangement. While these approaches are traditional, the Centers for Medicare and Medicaid Services (CMS) has been strongly encouraging states to move to more innovative and flexible approaches. An innovative alternative being considered by some states is contracting for claims processing as a service rather than implementing a new system.

Based on the alternatives assessment and a planned potential future state in which Nebraska Medicaid will pay few, if any, claims directly, the Medicaid and Long-Term Care Division (MLTC) has chosen to pursue claims processing as a service through a claims broker services (CBS) agreement. The CBS model seeks to partner with one or more of the managed care organizations (MCOs) in Nebraska that participate in risk-based Medicaid to also process fee-for-service (FFS) claims for clients and

services not in managed care. DHHS would not own the processing system or be responsible for its maintenance, but would set the policy and reimbursement rates and pass through the actual cost of the services. Operational functions would also be performed by the CBS.

Managing the data, producing accurate and timely reports, and utilizing the data to make informed business decisions has become more critical with the growth of the Medicaid program.

Moving to the CBS model provides an opportunity to implement a cost-effective solution to replace the remaining MMIS functionality. The CBS model will allow MLTC to avoid the high costs of replacing a full legacy MMIS. Procuring the necessary functionality using a best-of-breed, modular approach will not only meet future state requirements but also satisfy CMS requirements for innovative solutions. Modularity is one of the foundations necessary to secure federal matching funds for project planning and implementation.

MLTC will separately procure data management and analytics capabilities, which is considered by most experts as foundational to the future of health care. The data management and analytics (DMA) planning project will produce an RFP to provide MLTC with an enterprise data platform that will encompass MLTC/vendor systems and data in a holistic data solution. This will serve as the data management module for MLTC and be designed to “fit” within the overall architecture. Additional functionality such as financial management, eligibility and enrollment, etc. will be secured via existing or planned procurements with the same overarching modular approach.

GOALS

After considerable review of the programmatic goals of Nebraska Medicaid, the top priority for the project is providing Nebraska Medicaid with improved capability to manage the vast amounts of data received by the agency. Managing the data, producing accurate and timely reports, and utilizing the data to make informed business decisions has become more critical with the

growth of the Medicaid program. Over the next few years, Nebraska Medicaid will procure and implement a new data management and analytics solution to support and meet this priority.

Additionally, as Nebraska Medicaid integrates services under MCOs, the volume of FFS claims and the need for a separate and distinct infrastructure to support their processing will diminish. Therefore, over the next few years Nebraska Medicaid will also establish CBS with one of the Heritage Health MCOs to process FFS claims. This approach will capitalize on capacity and technological infrastructure already developed by the MCO and in place to pay claims through their at-risk business.



PROGRAM STRATEGY

As indicated above, achieving the goals to meet Nebraska Medicaid's business needs will require several years. The following strategic activities will be undertaken to progress toward those goals:

- Finalize the DMA RFP incorporating comments from draft
- Procure the DMA solution vendor that best meets the outlined requirements
- Continue outreach and communication with CMS to maintain ongoing federal funding for the project
- Finalize contract with the Heritage Health MCO that will perform as the CBS
- Prepare and execute a plan to support the implementation activities and align organizational resources to the new model
- Start implementing the DMA solution

DELIVERABLES

| Deliverable | Target Completion |
|---|-------------------|
| Release DMA RFP to vendors for comment | January 2016 |
| Submit DMA RFP to CMS for approval | March 2016 |
| Release DMA RFP solicitation for vendor bids | May 2016 |
| Vendor DMA proposals submitted | July 2016 |
| Publish DMA intent to contract | October 2016 |
| Submit DMA contract to CMS for approval | November 2016 |
| Finalize contract and start DMA implementation | February 2017 |
| Prepare plan to support implementation activities | February 2016 |
| Select Heritage Health Plan to perform as the CBS | April 2016 |
| Prepare organization to support implementation activities | January 2017 |
| Start joint planning and implementation preparations with CBS | February 2017 |

Veterans' Homes Electronic Health Record and Pharmacy Management Software

BACKGROUND

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009 to promote the adoption and meaningful use of health information technology. The Division of Veterans' Homes realized the importance of procuring a new electronic health record system and issued an RFP. The only bidder and subsequent award winner was eventually unable to fulfill the terms of the contract and it was terminated.

A decision was made to amend an existing contract with NETSMART and AVATAR, held by the Division of Behavioral Health, to serve as the electronic health record (EHR) system for the Veterans' Homes. AVATAR is designed as an acute care, mental and behavioral health medical record and does not specifically fit the needs of a geriatric, long-term care population. It was modified but is cumbersome and requires duplicate entry by multiple users to maintain duplicate data in a parallel system. Ideally, all patient information should

be maintained in an easily accessible system to avoid potential serious user errors.

In Fiscal Year 2015, the Division was re-appropriated funds to obtain a new congruent EHR, and a request for proposals was issued for an integrated, streamlined, robust long-term care EHR that has an integrated approach to clinical, long-term care minimum data set, care plans, assessments, progress notes, physician orders, electronic medication and treatment administration, physician/provider electronic billing, member billing, and member trust banking.

The Division of Veterans' Homes also issued a request for proposals for a new long-term care pharmacy management software and automated pharmacy packaging/dispensing machines. These systems must be able to provide a seamless real time interface with each other.

GOALS

The Division of Veterans' Homes is planning to select, purchase, and implement a new integrated EHR system. The requirements include converting data from our current (legacy) systems as soon as possible. Depending on the selection dates and contract negotiations, the new system is estimated to be live by the third quarter of Fiscal Year 2017.

PROGRAM STRATEGY

The Division of Veterans' Homes proposes a staggered approach to implementing the new system. The Grand Island Veterans' Home (GIVH) and the Western Nebraska Veterans' Home (WNVH) are using the legacy electronic medical record and pharmacy modules, making them the best candidates for initial implementation. GIVH will be the first facility to go-live with the new EMR, pharmacy software, and medication dispensing machines.

The second facility to go-live with all three components would be WNVH. The Eastern Nebraska Veterans' Home and Norfolk Veterans' Home will follow. Each facility's go-live would be at the end of month with patient records closing on the last day of the month, data converted and then on the first day of the month the new system would be live. Member statements will be produced out of the legacy system.

Both systems would run simultaneously, with the new system being the system of record but ensuring accuracy until the systems are audited and found to be in sync.

The implementation of all systems will require coordination so they occur at the same time since there is a dependency on each other. The following timeline will be adjusted if an additional Request for Proposal (RFP) process is necessary, and would be extended to February 2017.

DELIVERABLES

| Deliverable | Target Completion |
|--|-------------------|
| Electronic health record – RFP Scoring | December 2015 |
| Pharmacy management RFP – Scoring | December 2015 |
| Oral interview's/presentations | December 2015 |
| Intent to award posted | January 2016 |
| Final evaluation document | January 2016 |
| Contract finalization and award | March 2016 |
| Contractor start date | March 2016 |
| Project schedule due | March 2016 |
| Project management plan due | April 2016 |
| Project work plan due | May 2016 |
| Project kickoff meeting | May 2016 |
| Detailed system design document due | June 30, 2016 |
| Data migration plan due | June 30, 2016 |
| Testing plan due | June 30, 2016 |
| User acceptance testing plan due | June 30, 2016 |
| System implementation plan due | June 30, 2016 |
| Training plan due | June 30, 2016 |
| GIVH go live | August 1, 2016 |
| WNVH go live | September 1, 2016 |
| ENVH go live | October 1, 2016 |
| NVH go live | November 1, 2016 |

Behavioral Health Centralized Data System

BACKGROUND

The Division of Behavioral Health's reporting responsibilities stem from its designation as the state behavioral health authority. This authority is for mental health and substance abuse. As the state authority,



there is a responsibility for transparency in reporting and managing processes designed to provide prevention and treatment services to the consumers of behavioral health services in Nebraska.

The Division must provide reliable, accurate and current data to a variety of funding sources and system partners. These reporting requirements include monthly and annual Utilization and Financial Reports, National Outcome Measures (NOMs), and the Nebraska Uniform Reporting System (URS). In addition to planned reporting, a wide variety of requirements and report breakdowns for various funders and stakeholders are often requested on an ad hoc basis.

GOAL

The goal is to improve the data that informs service planning for the public behavioral health services for children and adults.

PROGRAM STRATEGY

A Centralized Data System (CDS) addresses the need for access to timely, reliable and accurate data essential for managing processes and serves as a foundational business practice that drives the Division's operational efficiency. The strategy is to develop a system that:

- ▶ Eliminates time consuming manual data collection and aggregation processes
- ▶ Provides updated technological tools for data analysis, data sharing, decision-making and quality improvement

- ▶ Standardizes data across the Division
- ▶ Increases access to underlying data
- ▶ Provides up-to-date data analysis necessary for reports and ongoing decision making

DELIVERABLES

| Deliverable | Target Completion |
|--|-------------------|
| Train regional center staff to include Results-Based Accountability (RBA) and CDS | March 1, 2016 |
| CDS implementation | April 15, 2016 |
| Onsite visits with Regions and ongoing CDS training | May 2016 |
| Develop reporting and timeframe mechanics of Memorandum of Understanding (MOU) currently in place with DHHS Medicaid that will provide for comprehensive examination of behavioral health services | June 30, 2016 |
| Work to initiate development of MOUs with other behavioral health system partners will be ongoing | December 31, 2016 |

Enterprise Technology Delivery

BACKGROUND

The DHHS Information Systems and Technology (IS&T) section is responsible for the development, delivery, security and management of technology platforms and solutions supporting Nebraska's most vulnerable citizens. The three major systems utilized by DHHS include:

- ▶ **NFOCUS** – an integrated system that automates benefit/service delivery and case management for more than 30 DHHS programs, including Child Welfare, Aid to Dependent Children, Supplemental Nutrition Assistance Program, and Medicaid
- ▶ **MMIS** – primary functions include fee-for-service claims processing and support for Medicaid managed care service delivery
- ▶ **CHARTS** – statewide Child Support Enforcement system, which includes case management, enforcement, financial management, and extensive integration with other state and federal agencies

In the past, many of the IT systems and supporting technologies were delivered within Division silos which limited reusability, increased IT costs, and in some instances, limited information technology expertise within the agency. Additionally, key systems (INFOCUS and MMIS) are scheduled for replacement as part of broader DHHS program initiatives in the 2016-2018 time frame, thus creating the need for the development of additional/new skillsets to successfully deliver, design, implement, and maintain the solutions going forward.

GOAL

The goal is to create an enterprise IT strategy within DHHS that provides a long-term foundation for cost effective innovation, consolidation, technological leadership, and sustainability.



PROGRAM STRATEGY

- New Medicaid solution for a Document Management Portal
- Establish an enterprise architecture and governance model for DHHS
- Look for intra-agency and inter-agency opportunities to consolidate IT platforms
- Include architectural components in RFP requests to introduce rigor with technological solutions and vendor management
- Continue to engage and build relationships within the program areas to facilitate IT vision
- Modernize skills within IS&T to support new technologies and program directives

DELIVERABLES

| Deliverable | Target Completion |
|--|-----------------------------------|
| Develop project plan for DHHS IT Infrastructure centralization with OCIO and complete Phase 1 of plan | March 2016 – December 2016 |
| Provide updated IS&T positions and current job descriptions for review by OCIO and HR | March 2016 |
| Identify necessary components for an Enterprise Architecture | June 2016 |
| Define project charter and project plan to make UNL Design Studio ACCESSNebraska mobile application prototype production-ready | June 2016 |
| Develop an initial Enterprise Architecture model and governance structure | September 2016 |
| Initiate product design to make UNL design studio ACCESS-Nebraska mobile application prototype production-ready | September 2016 |
| DHHS IT to centralize service desk software into OCIO platform, allowing the routing of tickets between Agencies and Teams | December 2016 |
| Develop position/staffing/training plans for IS&T in support of Curam product | December 2016 |

Increasing Operating Efficiencies and Improvements

Public Health Accreditation

BACKGROUND

In 2009, the Department of Health and Human Services received a National Public Health Improvement Initiative grant from the Centers for Disease Control and Prevention to accelerate public health accreditation readiness activities, implement performance and improvement management practices and systems, and implement and share practice-based evidence. Through this grant, the Division of Public Health began to prepare for national accreditation (meeting national standards and measures for public health departments) by developing and implementing the following plans and systems:

- Comprehensive statewide health assessment
- State Health Improvement Plan
- Division of Public Health Strategic Plan
- Quality Improvement Plan
- Workforce Development Plan
- Performance Management System

Through this work, the Division has made and continues to make improvements in the way it does business. The public health accreditation process involves submitting documentation to the Public Health Accreditation Board for review by a site visit team to determine if the Division is meeting national standards and measures and to what extent. After the site visit team reviews the documentation, they conduct a site visit and then provide a report to the Division outlining strengths and opportunities for improvement. The Public Health Accreditation Board makes a decision about accreditation status, either accredited for five years or development of a 12-month action plan and opportunity for resubmission.

In October 2014, the Division of Public Health submitted its application for accreditation through the Public Health Accreditation Board. Public health accreditation focuses on performance and quality improvement centered on the 10 Essential Public Health Services. In June 2015, staff submitted documentation to show how the Division is meeting national standards and measures. The Division's site visit is scheduled for January 2016.

GOALS

Key goals of public health accreditation include improved quality and performance of programs and systems to meet national public health standards, increased accountability and credibility, and continuous quality improvement.

PROGRAM STRATEGY

When the Division of Public Health accreditation site visit is complete in January 2016, the Public Health Accreditation Board will submit a report that includes



strengths and opportunities for improvement. We anticipate that by late spring 2016, the Public Health Accreditation Board will notify the Division about accreditation status, either accredited or development of a 12-month corrective action plan. If the Division receives an action plan, staff led by the Office of Community Health and Performance Management, with involvement from all units within the Division, will make required improvements and resubmit documentation within 12 months. When the Division receives full accreditation status, it will cover a period of five years.

Specific strategies for developing and implementing accreditation efforts will involve the following:

- Update statewide health assessment, state health improvement plan, and Division strategic plan. These are the required prerequisites for accreditation and must be updated every five years.
- Expand and maintain a performance management system including continuous quality improvement. Maintaining a performance management system which includes continuous quality improvement is a requirement of public health accreditation. The Division recognizes the need to expand the current performance management system and continue quality improvement efforts.

- ▶ Prepare action plan for responding to accreditation results. Based on the results of the accreditation process, the Division will create an action plan to respond to the opportunities for improvement noted by the site visit team.
- ▶ Implement performance and quality improvement efforts. The Division will begin to implement performance and quality improvement efforts based on accreditation results.

DELIVERABLES

| Deliverable | Target Completion |
|--|-----------------------|
| Accreditation site visit | January 2016 |
| Update statewide health assessment | January-March 2016 |
| Action plan for responding to accreditation results | April-June 2016 |
| Complete state health improvement plan and Division strategic plan | October-December 2016 |
| Expand performance dashboards covering all Division Units | April-June 2017 |
| Have at least four performance and quality improvements based on action plan | April-June 2017 |

LPN/RN Licensure Application Improvements

BACKGROUND

The Department of Health and Human Services (DHHS) Operations Consulting team reviewed the processes and procedures for the initial Licensed Practical Nurse/Registered Nurse (LPN/RN) applications to provide recommendations for improving turnaround time. During September 2015, operations consultants job shadowed each of four nursing licensure specialists to document the current process.

GOAL

The overall goal is to improve the length of time required to process an application for initial licensure as an RN or LPN.

PROGRAM STRATEGY

The following findings are based on job shadowing of the nursing licensure staff, meetings with program staff, surveying of recently licensed nurses, and

reviewing of other states' processes and applications. Data was also taken from the Licensure Information System (LIS) to find trends, areas of improvement, and strengths. The issues below are ordered in priority (1 highest priority, 6 lowest priority) and anticipated to provide the highest return on investment.



1. The current LPN/RN application has over 100 fail points for applicants and contains redundant portions leading to applicant confusion. Approximately 80 percent of applications currently arriving contain deficiencies or do not include all supporting documentation. This results in applications needing to be sent back to the applicant or waiting for supporting documentation to arrive before the application can be fully processed.
2. There is approximately a 30-day backlog for pending applications awaiting additional documentation from applicants.
3. Benchmarks and process expectations are not clearly defined.

4. The work process flow is being interrupted by the amount of phone calls being received. Currently, licensure specialists receive a phone call approximately every 10-20 minutes.
5. The webpages pertaining to the LPN/RN license process can be difficult to find along with the information within each webpage.
6. Currently, only a paper application process exists. This does not allow for applicants to easily submit information. The paper process can also be inefficient due to forms being mailed between the applicant and the licensure staff.

Specific recommendations and strategies over the coming months for developing and implementing improvements to the LPN/RN initial application process include the following:

- ▶ **Revise the LPN/RN licensure application.** Create different applications for examination and endorsement. Review for consistent language and terminology throughout both applications. Have outside resources review the application for feedback. Place licensure unit phone number at end of application. Provide training for nursing licensure specialists on application requirements and expectations. Disperse new application to users via website and stakeholders; for example, colleges, employers, etc.

Continue pilot project. In October 2015, DHHS staff started to notify applicants who have incomplete applications within three working days of receiving the application. Continue that process and track data. Conduct weekly meetings to discuss the amount of applications processed, common calls, and overcoming obstacles. Hold daily huddles with staff to provide guidance/oversight. Review pilot project for effectiveness and enhancements.

Provide clear expectations and benchmarks for staff. Create weekly benchmark expectations for staff. Hold weekly meetings to discuss prior week's production, current week's expectations, staff concerns, etc. Implement reviewing a quarterly sample of each licensure specialist's processed applications to ensure accuracy.

Re-evaluate benchmarks for improvements and increased production.

- ▶ **Reduce the amount of phone calls received.** Further explore the possibility of a voice automated routing system to direct callers to the appropriate licensure specialists. Put contact information for nursing licensure specialists at the end of forms, documents, or webpages. Revise frequently asked questions on website to give clear and direct answers that set realistic expectations.

Revise the website to provide easy access to LPN/RN applications. Run analytics on the licensure homepage to determine most frequently visited webpages. Revise frequently asked questions to provide clear direction and realistic expectations for LPN/RN applicants. Create a consistent layout for each licensure webpage. Provide information in drop down menus to organize material/information. Gather feedback from end users. Create document library for forms and applications.



DELIVERABLES

| Deliverable | Target Completion |
|---|-----------------------|
| Project kickoff | September 2015 |
| Obtain input from stakeholders on revised LPN/RN licensure application | January 2016 |
| Continue customer-focused upgrades to licensure website including streamlining pages, revising FAQs and creating a library of applications for easier access | February 2016 |
| Conduct presentations at nursing schools to orient graduating students to completing the revised application | February 2016 |
| Implement automated phone attendant | March 2016 |
| Continue pilot project of responding to applications within three days | Ongoing |
| Evaluate data to establish achievable expectations and benchmarks | Ongoing |
| Continue to work with the Office of the Chief Information Officer and DHHS Information Systems and Technology to provide online submission for initial applications | Ongoing |

Central Nebraska Veterans' Home

BACKGROUND

The Grand Island Veteran's Home (GIVH), originally known as the Nebraska Soldiers and Sailors Home, opened in Grand Island in 1887 and was the first veterans' home in Nebraska. The current total capacity at the facility is 266.

GIVH is being replaced in order to meet the long-term care needs of Nebraska veterans by providing a facility that meets the United States Department of Veterans Affairs (USDVA) standards and guidelines. GIVH has building deficiencies which do not conform to current best practices of the USDVA Community Living Centers.

A major objective of the design is to develop an enhanced living environment for veterans that is more like home and less institutional than the traditionally designed nursing home, which has been historically based on a hospital model with wards. The proposed facility will provide a member-centered environment

that focuses care and resources around the individual members in an effort to improve and enhance their quality of life.

The new facility will be comprised of a series of neighborhood homes that are clustered in groups of three and interconnected in neighborhood groupings of three as well. These clusters connect to hubs and these hubs in turn connect to the Veterans' Home Center. Provision of individual member bedrooms, large gathering spaces, social activity spaces, therapy centers, views to nature, household gardens, and a fishing pond all serve to enhance the quality of life for veterans while providing privacy, security, and the capacity for interaction.



Features and characteristics of the Central Nebraska Veterans' Home will include:

- 225 private bedrooms and private baths
- 18 individual home environments including dining, activity, living, laundry, and den space
- 2 physical therapy and large group activity spaces
- Large group/assembly room for campus events
- Chapel
- Wood shop
- Craft area
- Specialized dining – Foxhole Pub area providing meal choice options
- Clinic area and pharmacy support
- Barber shop and beauty salon

The facility also incorporates adequate support and administrative services. The entire facility will be

335,000 square feet constructed on a 67-acre site located at the intersection of 56th Street and Cherry Avenue in Kearney. Completion and move-in are planned for Fall 2018.

GOALS

The goals are to meet the construction timeframes, to prepare and support current employees and members for the transition, and to work with the City of Kearney and others in the recruitment, and referral of new employees and volunteers.

PROGRAM STRATEGY

The Division will provide ongoing involvement and support through the construction phases to the Nebraska Department of Administrative Services, the lead state agency for construction of the new Central Nebraska Veterans' Home. Knowledge of and communication regarding USDVA requirements is paramount. The project falls under the USDVA State Home Construction Grants Program which provides the overall guidance and regulations governing the construction of State Veterans' Homes. The planning and design process follows USDVA design criteria, the USDVA Community Living Center Design Guide and applicable codes for design and construction.

The Division of Veterans' Homes is responsible for an extensive transition plan for employees and members. In partnership with DHHS Human Resources and Development, a number of components to support employees have been identified as possible activities, including a recruitment and referral program, holding courses for certified nursing assistants in Kearney, planning transportation options between Grand Island and Kearney, developing a retention incentive, writing necessary new job descriptions, determining the need to contract with a staffing agency, and job placement and retraining opportunities.

Preparing the members for the transition to a new facility will be a priority with a focus on managing the census as completion of the facility nears, developing and recruiting for a buddy program specific for the move, training volunteers in the new community, and familiarizing members with the new facility. The logistics of the move day will be significant with details developed as the move approaches.

The construction target completion dates are contingent on timing of contract awards and federal approval.

DELIVERABLES

| Deliverable | Target Completion |
|---|-----------------------|
| Construction | |
| Construction contracts awarded | January 2016 |
| State of Nebraska submits CNVH for USVA final cost approval | January 8, 2016 |
| Grant deadline (180 days from conditional approval letter) | March 25, 2016 |
| Construction begins | April 1, 2016 |
| Construction complete; members move in | Fall 2018 |
| Staff transition | |
| Staff recruitment and referral program | June 2016 - move in |
| Kearney CNA class | January 2016 ongoing |
| Transportation | January 2016 ongoing |
| Retention incentive | Fall 2018 |
| Develop geriatric Support Specialist job description | Fiscal Year 2017 |
| Contract with staffing agency | July 2016 ongoing |
| Job placement/retraining | Fiscal Year 2018 |
| Move day | Fall 2018 |
| Member transition | |
| Moving buddy program | Summer 2018 - move in |
| Volunteer training | Summer 2018 |
| Facility familiarization | Fiscal Year 2018 |
| Move day | Fall 2018 |

Employee Recruitment and Retention

BACKGROUND

Proactive strategic human resources operations are critical for overall agency effectiveness. DHHS employees are the primary component of agency success. Recruiting, developing, and retaining outstanding people is the primary mission of Human Resources and Development.



In alignment with the overall agency goals, Human Resources and Development will establish priorities, streamline and enhance processes to improve operations and enhance customer service.

A number of HR-related issues have been identified that will be included in these activities. The average number of days to post an open

position is 34.6. The average length of time from post to offer is 74.79 days, and the 2015 annual turnover held at 19.1 percent. Thirty-three percent of the DHHS workforce is currently eligible to retire; yet, the Agency does not have a formal succession planning program or process to transfer knowledge.

GOAL

The goal is to develop new and enhance existing HRD operations to build a foundation for long-term strategic innovation and proactive program development.

PROGRAM STRATEGY

- ▶ Put recruitment model in place which allows for the acquisition of top talent through effective recruitment strategies and efficient recruitment processes
- ▶ Improve employee retention by creating opportunities for workplace resilience, and develop and implement a strategy around "stay interviews"
- ▶ Develop a comprehensive communications and measurement plan that outlines in detail the

partnership between recruitment, DHHS managers and training in the effective on-boarding, training, and development of newly hired and newly promoted employees

- ▶ Identify key performance indicators and develop assessment tools to measure effectiveness of operations and programs
- ▶ Develop internal capacity for program development through continued organizational structure review
- ▶ Establish program development priorities to achieve identified short- and long-term talent acquisition and employee development needs

DELIVERABLES

| Deliverable | Target Completion |
|--|-------------------------|
| Identify internal metrics, assessment processes, and/or data analysis to assess operational effectiveness and identify opportunities for improvement | January - March 2016 |
| Identify a process and format for regular reporting metrics and assessments to stakeholders and internal customers | January - March 2016 |
| Utilize metrics to identify initial priorities to stabilize workforce and HR operations | April - June 2016 |
| Identify an organizational structure to support program development and enhanced customer service | April - June 2016 |
| Initiate process improvement activities for key operations | April - June 2016 |
| Identify key bargaining proposals for inclusion in contract negotiation and submit to DAS-Employee Relations | April - June 2016 |
| Establish timelines and resources for program development to address priorities identified through analysis of established metrics and assessment processes | June - September 2016 |
| Provide updates and reports of qualitative and quantitative to stakeholders and internal customers and establish ongoing priorities for additional program development | October - December 2016 |

Improve Flow and Decrease Wait List at Lincoln Regional Center

BACKGROUND

The population at the Lincoln Regional Center (LRC) includes individuals who were ordered there by the court, including those incompetent to stand trial, competency evaluations, and not responsible for reasons of insanity; individuals who have been deemed sex offenders; and individuals under mental health board (MHB) commitments.



LRC experiences a waiting list. If at any time it becomes necessary, for lack of capacity or other cause, to establish priorities for the admission of patients into the state hospitals for the mentally ill, the following priorities for admission are recognized: (1) Patients whose care in the state hospital is necessary in order to protect public health and safety; and (2) patients committed by a mental health board under the Nebraska Mental Health Commitment Act, the Sex Offender Commitment Act, or by a district court. A focus is to return consumers to a community setting of their choice through the assistance of partners throughout the system.

GOAL

Increase access to appropriate and effective integrated behavioral health services, particularly for individuals with complex needs.

PROGRAM STRATEGY

Improve flow and decrease the wait list at Lincoln Regional Center.

DELIVERABLES

| Deliverable | Target Completion |
|---|-------------------|
| Identify and develop community-based hospital and emergency system options for Behavioral Health Region V consumers needing inpatient care | December 31, 2016 |
| Identify and develop intermediate service options/plan to reduce admissions to Lincoln Regional Center <ul style="list-style-type: none"> Identify placement and service options for LRC consumers by Cross-Division Solutions Team Develop health information technology and telecommunications options Enhance community-based service options | December 31, 2016 |
| Explore development of a mechanism for applying population management processes to other Behavioral Health Regions | December 31, 2016 |
| Continue Division Integration and Clinical Improvement/Quality Improvement Project <ul style="list-style-type: none"> Review NRC/LRC Sex Offender Programs – Admission and discharge flow within LRC Develop recommendations that will improve flow Attend quarterly meetings with Administrative Office of the Courts | December 31, 2016 |

Maintain and Improve ACCESSNebraska Performance for Economic Assistance Programs

BACKGROUND

Economic Assistance delivers services for federal programs including: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), Low-Income Home Energy Assistance Program (LIHEAP), Assistance to Aged Blind and Disabled (AABD), Child Care, and Social Services Block Grant (SSBG). In Nebraska, TANF includes Aid to Dependent Children (ADC) and Employment First.

In November 2015, approximately 9 percent of Nebraska's population received SNAP, or 77,976



households with 174,887 individuals. ADC recipients totaled 5,772 families, and 17,999 children were in the Child Care Subsidy program. Each month approximately 8,000 applications are received for Economic Assistance programs, and over 40,000 telephone calls are made to the Customer Service Centers in Fremont and Scottsbluff.

The Department of Health and Human Services administers and manages eligibility for both Economic Assistance programs and Medicaid and Long-Term Care through a service delivery system known as ACCESS-Nebraska. ACCESSNebraska started in September 2008, with a public website containing an online application for benefits, and was fully implemented in April 2012.

ACCESSNebraska's operations include the following components:

- ACCESSNebraska.ne.gov website
- Document management with two imaging centers (Lincoln and Omaha)

- Customer Service Centers for Economic Assistance (Fremont and Scottsbluff) and Medicaid (Lexington and Lincoln)
- Local offices (over 50 throughout Nebraska)
- NFOCUS eligibility system

In May 2015, ACCESSNebraska began operating with a cross-divisional team focused on addressing operational improvements through a series of process initiatives. Operational improvements are driven by the following areas of focus:

- Document intake and processing
- Call management
- Field operations and task management
- Recruiting and retention
- Policy reviews and enhancements
- Workforce management/capacity planning
- Client/user communications
- Legislative reporting
- Change management
- UNL mobile application project

Significant strides have been made in the past year in the performance and efficiency of ACCESSNebraska for Economic Assistance programs:

- The average call wait time at the Economic Assistance Customer Service Centers dropped from 21 minutes and 24 seconds in January 2015 to 5 minutes and 34 seconds in December 2015
- The average days to process economic assistance applications dropped from 18.70 days in January 2015 to 14.32 days in December 2015
- The SNAP initial expedited application timeliness increased from 94.44 percent in August 2014 to 99.28 percent in December 2015
- SNAP initial non-expedited application timeliness increased from 70.61 percent in August 2014 to 96.75 percent in December 2015
- The SNAP recertification timeliness increased from 61 percent in August 2014 to 94.25 percent in December 2015

GOAL

The Division of Children and Family Services will continue to evaluate and implement more efficient and effective systems in ACCESSNebraska for Economic Assistance programs to improve customer service and long-term performance in areas such as call wait times and timeliness.

PROGRAM STRATEGY

- ▶ Hold daily management huddles to communicate performance and the emphasis of daily work
- ▶ Place performance dashboards on the internal and external websites to communicate progress
- ▶ Increase client accessibility to Economic Assistance programs by adding the ability to apply and recertify/review benefits via the telephone
- ▶ Utilize email and text messaging to increase communication with clients providing increased communication options in addition to relying on U.S. mail
- ▶ Utilize workforce management/capacity planning calculations to assess and assign staffing to meet program targets
- ▶ Increase and improve online/mobile services available for clients
- ▶ Increase the amount of applications processed the same day the application is received utilizing electronic verification sources
- ▶ Increase client communication on review/recertification timelines by utilizing multiple communication methods other than U.S. mail
- ▶ Utilize program policy enhancements to assist staff in the recertification process
- ▶ Allow clients the option to receive electronic notifications only
- ▶ Increase the amount of information available in the online accounts and via Interactive Voice Response (IVR) Self Service
- ▶ Implement quarterly address checks utilizing mail software to keep addresses current
- ▶ Implement the use of Intelligent Mail to track the delivery of mail to ACCESSNebraska

- ▶ Utilize workforce management to forecast the amount of staff needed to handle the phone volume
- ▶ Implement the findings of the LR 33 ACCESSNebraska Special Investigative Committee and other legislative studies

DELIVERABLES

| Deliverable | Target Completion |
|--|----------------------------------|
| Process all Economic Assistance program applications in an average of 10 days | April 2016 and ongoing |
| Process all Economic Assistance program applications within the federal timelines 95 percent of the time | Ongoing |
| Decrease by 10 percent the amount of benefit interruptions caused by untimely review/recertification processing | April 2016 and ongoing |
| Process all Economic Assistance program reviews/recertifications within the federal timelines 95 percent of the time | February 2016 and ongoing |
| Improve client communication by reducing the amount of returned mail by 25 percent from 2015 levels | October 2016 |
| Improve customer service by answering calls to the Customer Service Centers quickly. ACCESSNebraska will have an average call wait time of 5 minutes | Ongoing |

Single Audit Corrective Action Plans

BACKGROUND

The Nebraska Auditor of Public Accounts audits the State of Nebraska Comprehensive Annual Financial Report (CAFR) as well as conducts the Statewide Single Audit to ensure compliance with state and federal laws and to assess the adequacy of current controls over expenditures by state agencies.

Single Audit findings regarding DHHS programs have been identified as a significant risk for DHHS by both senior management and external stakeholders. DHHS is responsible for promptly responding to the issues noted in the audit reports and taking appropriate

corrective action steps to ensure compliance with applicable criteria and efficient operations.

GOAL

The goal is for all corrective action plans to be fully implemented no later than June 30 of the fiscal year immediately following the audit period in which the finding was identified.

PROGRAM STRATEGY

Each audit finding is assigned to DHHS staff who are responsible for drafting, approving, and implementing a corrective action plan.

The corrective action plan must also include a detailed implementation plan which outlines specific action steps for achieving the corrective action plan.

All corrective action and implementation plans will be reviewed and tested for compliance by the Internal Audit Section.

DELIVERABLES

| Deliverable | Target Completion |
|---|-------------------|
| Internal audit report for each finding to include the opinion of the Internal Audit Section on the completeness and adequacy of the corrective action plan | Ongoing |
| Tracking matrix for all Single Audit findings available for all DHHS employees, including management, to view the status of corrective action plan implementation | Ongoing |
| Quarterly meetings with each Division's Senior Management team to provide status updates | Ongoing |



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DHHS Mission:

"Helping People Live Better Lives"

DHHS Values:

Constant Commitment to Excellence:

Takes timely action in regard to tasks or information; works to eliminate mistakes; looks for, and embraces, opportunities for organizational improvements; actively seeks to provide prompt, efficient, and courteous service; shows initiative.

High Personal Standard of Integrity:

Avoids any impropriety, bias, or conflict of interest; follows through on commitments; is truthful; shows good judgment in decisions made.

Positive and Constructive Attitude and Actions:

Maintains constructive communication with others; supports co-workers, customers, and clients; expresses appreciation for the efforts and work of others; is constructive and helpful.

Openness to New Learning:

Open to new ideas and trying new ways of doing things; open to the idea that a given view or opinion is often made better by the input of others; open to the challenge of unfamiliar tasks and problems.

Dedication to the Success of Others:

Aids in the growth and success of colleagues; treats all people with respect and dignity; views the success of the whole as a personal success; gives the assumption of good intent to others.

DHHS Core Competencies:

Demonstrates Responsibility & Accountability:

Cares for and maintains equipment/facilities; conserves supplies and funds; takes responsibility and is reliable for completing assigned tasks; acknowledges and corrects mistakes; adheres to the expectations of their supervisor.

Demonstrates Professional Composure:

Demonstrates calm, dignity and self control under pressure; defuses situations with empathy and respect.

Demonstrates Effective Interpersonal Relationships:

Works to gain the trust of others; demonstrates courtesy, and civility; is open and transparent with tact; is sensitive and attentive while doing active listening; promptly and effectively deals with conflict; shares opinions while respecting the differing opinions of others.

Demonstrates Productive Communication:

Demonstrates good oral, written, and listening skills; contributes to effective meetings; clearly and accurately shares information.

Demonstrates Support of Their Team:

Shows respect for team leadership; promotes a friendly climate, good morale, and cooperative team relationships; values all team members.

Demonstrates Self-Improvement:

Participates in training and development opportunities; welcomes new learning and the challenge of unfamiliar tasks; seeks to do the job better.

***Demonstrates Motivating Others:**

Inspires, motivates, and guides others toward accomplishing their work; gives recognition for contributions.

***Demonstrates Developing Others:**

Clearly defines expectations; invests time and effort to improve performance; knows all direct reports, and recognizes unique skills and temperament of each; uses an array of development tools; links individual performance to organizational goals.

**for supervisors*